



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Trenton D. Weeks, D.C.

Respondent Name

TASB Risk Management Fund

MFDR Tracking Number

M4-17-1659-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

February 1, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Previous MMI certification does not negate the injured employee's entitlement to subsequent MMI/IR evaluations by certified doctor."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary:

- "Dr. Brooks performed a designated doctor's examination on 11/12/14, claimant was found not at MMI
- The injured worker disputed the designated doctor (DD) findings...
- The injured worker requested an alternate rating by Dr. Weeks on 11/19/15. The claimant was then found to be not at MMI ...
- The CCH officer issued a decision and order on 2/10/16 indicating the injured worker is at MMI on 09/04/14 with an impairment of 1%...
- On 03/10/16 the selected doctor (Dr. Weeks) performed an additional exam for MMI and impairment rating. Dr. Weeks did not submit any new evidence that ... there was change in diagnosis and again indicated the injured worker was not at MMI"

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 10, 2016	Referral Doctor Examination to Determine Maximum Medical Improvement	\$350.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.0041 sets out the requirements for designated doctors.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 150
 - 193
 - W3
 - Note: "Not at MMI"
 - Note: "Payment adjusted because the payer deems the information submitted does not support this level of service."
 - Note: "This eval was not requested or authorized to be done. Another alternate mmi/ir was done on November."
 - Note: "Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly."
 - Note: "Additional payment made on appeal/reconsideration."
 - Note: "12/8/16 – Rule 134.804(a) Services reviewed for reconsideration. Additional payment made or service adjustment amount may be zero."
 - Note: "12/8/16 – Maintaining denial based on documentation does not meet the criteria of Rule 126.17."

Issues

Is Trenton D. Weeks, D.C. entitled to additional reimbursement?

Findings

Trenton D. Weeks, D.C. is seeking reimbursement of \$350.00 for an examination to determine maximum medical improvement. In his position statement, Dr. Weeks argues that the disputed examination was performed as "an Alternative MMI/IR evaluation in order to dispute a DD evaluation." Dr. Weeks also argues that

As of September 1, 2011 Section 408.0041(f-2) and 408.0041(h) of the Texas Labor Code require the workers' compensation insurance carrier to pay for treating doctor or referral doctor examination to certify MMI and IR when MMI and IR have first been certified by a designated doctor and the injured employee disagrees with the designated doctor's opinion.

TASB Risk Management Fund (TASB) denied the services stating, "This eval was not requested or authorized to be done. Another alternate mmi/ir was done on November."

Texas Labor Code §408.0041 provides, in relevant part, that:

- (f-2) An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement and the employee's impairment rating from the treating doctor or from another doctor to whom the employee is referred by the treating doctor if:
 - (1) the designated doctor's opinion is the employee's first evaluation of maximum medical improvement and impairment rating; and
 - (2) the employee is not satisfied with the designated doctor's opinion.
- (f-3) The commissioner shall provide the insurance carrier and the employee with reasonable time to obtain and present the opinion of a doctor selected under Subsection (f) or (f-2) before the commissioner makes a decision on the merits of the issue.

Further, Texas Labor Code §408.0041(h) does require the insurance carrier to reimburse the provider if an examination was performed in accordance with Subsection (f-2), as argued by Dr. Weeks.

The division reviews available documentation to determine if the examination in question met the requirements of Texas Labor Code §408.0041(f-2). The division finds that:

- a previous examination was performed that met the requirements of Texas Labor Code §408.0041(f-2)

- a hearing officer submitted a decision on February 4, 2016, deciding that the injured employee had reached maximum medical improvement and provided the date it was reached.

Texas Labor Code §408.0041(f-2) does not provide for the injured employee to request multiple examinations, or to request examinations after a decision has been rendered by a hearing officer. The evidence does not support that the examination in question met the requirements of Texas Labor Code §408.0041. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____	_____	_____
Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	March 3, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.